

may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

8985

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

08955

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) ✓ a. STATE <b>Maryland</b> b. COUNTY <b>Balto. City</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. LENGTH OF STAY IN 1b <b>22yrs. 1mo. 10days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Springfield State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>Edward</b> Last <b>Anderson</b>				4. DATE OF DEATH Month <b>August</b> Day <b>22</b> Year <b>1960</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>July 3, 1901</b>		9. AGE (In years last birthday) <b>59</b> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Harry Anderson</b>				14. MOTHER'S MAIDEN NAME <b>Addie Sakers</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT Address <b>Springfield Hospital Records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> DUE TO 350X Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <b>Parkinsonism</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Psychosis with post-encephalitis.</b>							INTERVAL BETWEEN ONSET AND DEATH <b>Years</b>  <b>Years</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>March 7, 1955</b> to <b>August 22, 1960</b> , that (I) (we) last saw the deceased alive on <b>August 22, 1960</b> , and that death occurred at <b>11:05 PM</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Agustin del Campo</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>8/23/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b>				22d. ADDRESS <b>Springfield Hospital, Sykesville, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8-27-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur H. Haight</b>				25a. REC'D BY REGISTRAR <b>AUG 31 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

1



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JAN 10 1964  
U.S. DEPT. OF JUSTICE



RECEIVED  
JAN 10 1964  
U.S. DEPT. OF JUSTICE

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TO HOSPITAL OR ATTENDING PHYSICIAN: Law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8986

08956

Item 1 Film 6270 4-6-60 et

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
c. LENGTH OF STAY IN 1b <b>2 Mos. 23 Days</b>		d. STREET ADDRESS <b>3337 N. Charles St., Balto. 18, Md.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Katherine</b> Middle <b>Butler</b> Last <b>Blanck</b>		4. DATE OF DEATH Month <b>August</b> Day <b>24</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-12-89</b>
9. AGE (In years lost birthday) <b>72</b> yrs.		10. IF UNDER 1 YEAR Months <b>72</b> Days <b>0</b> Hours <b>0</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James Butler</b>		14. MOTHER'S MAIDEN NAME <b>Anastasia Concoran</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Springfield Hospital Records, Sykesville, Md.</b>	
17. INFORMANT <b>Springfield Hospital Records, Sykesville, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>331X</b> IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage due to hypertension.</b> DUE TO (b) <b>10 days.</b> DUE TO (c) <b>Hypertension</b> years. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>C.B. S. assoc. with cerebral arteriosclerosis with psychotic reaction.</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20a. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20e. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>June 1, 1960</b> to <b>August 24, 1960</b> , that (I) (we) last saw the deceased alive on <b>August 24, 1960</b> , and that death occurred at <b>12:30 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Agustin del Campo</b>		22b. DATE SIGNED <b>August 24, 1960</b>	
22c. PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b>		22d. ADDRESS <b>Springfield State Hospital, Sykesville, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Aug 27, 1960</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>John A. Moran</b>		25a. REC'D BY REGISTRAR <b>AUG 29 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles S. Kraus</b>		25c. ADDRESS <b>3000 E. Baltimore St.</b>	

BP

08356

CERTIFICATE OF DEATH

8228



TO HOSPITAL OR ATTENDING PHYSICIAN: This low requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

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CERTIFICATE OF DEATH

1981

(M)



(L)



1. Name of deceased: [illegible]  
2. Date of death: [illegible]  
3. Place of death: [illegible]  
4. Cause of death: [illegible]  
5. Signature of physician: [illegible]  
6. Signature of registrar: [illegible]  
7. Date of registration: [illegible]



**DEPUTY MEDICAL EXAMINER:** The certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**TITICUM RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8987

08958

1. PLACE OF DEATH a. COUNTY <b>Carroll</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Carroll</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Westminster</b>		c. LENGTH OF STAY IN lb <b>HOURS</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Union Bridge</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>RURAL</b>		d. STREET ADDRESS <b>R 140 18 So. MAIN ST</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>GEORGE K. BOSTIAN</b>		4. DATE OF DEATH <b>August 30, 1960</b>		5. SEX <b>Male</b>	
6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4/21/1922</b>	
9. AGE (In years last birthday) <b>38</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER CONSTRUCTION</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>WILLIAM H. BOSTIAN</b>		14. MOTHER'S MAIDEN NAME <b>MARY GRIM</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. <b>217-18-8743</b>		17. INFORMANT <b>W. H. BOSTIAN, UNION BRIDGE</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic coronary disease with old infarct</b> <b>428.1</b> <b>MI</b> of left anterior ventricle Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>DUE TO</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> el work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I took charge of the remains described above, held an <b>Autopsy</b> <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Russell S Fisher</b>		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>8/31/60</b>	
EXAMINER'S NAME (Type) <b>Russell S. Fisher, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>9/2/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>WINTERS CEM</b>	
22d. LOCATION (City, town, or country) <b>CARROLL COUNTY, MD</b>		22e. REC'D BY REGISTRAR <b>SEP 6 '60</b>		22f. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

001324

CERTIFICATE OF DEATH

1987

FOR STATE  
VITAL RECORDS

County of

City of

Age

Sex

Dec. 1987

Dec. 1987

Dec. 1987

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may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
 MYRSD STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8988

08959

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto. City</b> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. LENGTH OF STAY IN 1b <b>6 yrs. 9 mos. 20 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 13</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				d. STREET ADDRESS <b>29 S. Washington St.</b>			
3. NAME OF DECEASED (Type or print) First <b>Franklin</b> Middle <b>Carl</b> Last <b>Cummings</b>				4. DATE OF DEATH Month <b>August</b> Day <b>26</b> Year <b>1960</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>October 28, 1929</b>	
9. AGE (In years last birthday) <b>30</b> yrs.		IF UNDER 1 YEAR Months <b>30</b> Days <b>0</b> Hours <b>0</b> Min.		IF UNDER 24 HRS. Hours <b>0</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Stock clerk</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Vincent Cummings</b>				14. MOTHER'S MAIDEN NAME <b>Barbara Kress</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>217-24-5896</b>		17. INFORMANT <b>Springfield Hospital Records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cancer of pancreas with metastasis</b> DUE TO (b) <b>157X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <b>Schizophrenic reaction, psychotic, undifferentiated type.</b>				INTERVAL BETWEEN ONSET AND DEATH <b>Months</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Schizophrenic reaction, psychotic, undifferentiated type.</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>November 6, 1953</b> , to <b>August 26, 1960</b> , that (I) (we) last saw the deceased alive on <b>August 25, 1960</b> , and that death occurred at <b>3:05 AM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Agustin del Campo</b>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>8/26/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b>				22d. ADDRESS <b>Springfield Hospital, Sykesville, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>8-30-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook, Inc., 1217 St. Paul Street</b>				25a. REC'D BY REGISTRAR DATE <b>AUG 30 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kress</b>	

(M)

014

(I)

2326

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. Prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

8989

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

08960

1. PLACE OF DEATH a. COUNTY <b>CARROLL CO. MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> COUNTY <b>CARROLL</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAMPSTEAD</b>		c. LENGTH OF STAY IN 1b <b>7 MIS.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAMPSTEAD</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>—</b>				d. STREET ADDRESS <b>DAVE RILL RD. 1</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>EMMANUEL Bostick Cunningham</b>				4. DATE OF DEATH Month Day Year <b>Aug 20 1960</b>			
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>MAY 1, 1888</b>	
9. AGE (In years last birthday) <b>72</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TELEGRAPHER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>RAIL ROAD</b>		11. BIRTHPLACE (State or foreign country) <b>PENNSYLVANIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>ALBERT CUNNINGHAM</b>				14. MOTHER'S MAIDEN NAME <b>MARY MCCARDEL</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>(If yes, give war or dates of service)</b>		16. SOCIAL SECURITY NO. <b>705-05-7951</b>		17. INFORMANT Address <b>MRS. CUNNINGHAM HAMPSTEAD MD</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO INTERVAL BETWEEN ONSET AND DEATH <b>1 hr</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>W. H. Foard</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>W. H. Foard M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>8/23/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>MEADOWRIDGE CEM.</b>		22d. LOCATION (City, town, or county) (State) <b>LAWAL MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James G. Saffell Westminster MD.</b>				24a. REC'D BY REGISTRAR <b>AUG 23 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Robert S. Funn</b>	

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1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

1  
8990  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
08961

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. LENGTH OF STAY IN 1b <b>1 yr. 19 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Margaret</b> Middle <b>Finn</b> Last <b>du Bois</b>				4. DATE OF DEATH Month <b>August</b> Day <b>3</b> Year <b>1960</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>February 17, 1905</b>	
9. AGE (In years last birthday) <b>55</b> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Michael Finn</b>				14. MOTHER'S MAIDEN NAME <b>Ella Brannen</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>214-01-7732</b>		17. INFORMANT <b>Springfield Hospital Records, Sykesville, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost, (b) <b>Infected decubitus ulcers</b> DUE TO (c) <b>Metastatic carcinoma in the liver and thoracic spine secondary to carcinoma of the breast.</b>				INTERVAL BETWEEN ONSET AND DEATH <b>24 hours</b> <b>Weeks</b> <b>Unknown</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Depressive Reaction</b>				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>July 14, 1959</b> to <b>August 3, 1960</b> , that (I) (we) last saw the deceased alive on <b>August 3, 1960</b> , and that death occurred at <b>8:05 P.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Agustin del Campo</b>				22b. DATE <b>August 3, 1960</b>			
22c. PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b>				22d. ADDRESS <b>Springfield Hospital, Sykesville, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8/8/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Moreland Memorial Pk. Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. T. ...</b>				ADDRESS <b>Baltimore - Md</b>		25a. REC'D BY REGISTRAR <b>DATE AUG 8 '60</b>	
				25b. REGISTRAR'S SIGNATURE <b>C. ...</b>			

8330

CERTIFICATE OF



1907

*[Faint, mostly illegible text, likely bleed-through from the reverse side of the page. Some words like "CERTIFICATE", "OF", and "1907" are visible.]*



## CERTIFICATE OF DEATH

Reg. Dist. No.

08962

8991

(M)

1. PLACE OF DEATH  
a. COUNTY

Carroll

MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)  
o. STATE

Maryland

b. COUNTY

Carroll

## b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Rural - Sykesville

## c. LENGTH OF STAY IN 1b

2yr.1mo.12days

## c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Rural - Woodbine

## d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

Springfield State Hospital

## d. STREET ADDRESS

Route # 1

## e. IS RESIDENCE ON A FARM?

YES ☐ NO ☒3. NAME OF DECEASED  
(Type or print)First  
FannieMiddle  
LouiseLast  
ESCAVILLE

## 4. DATE OF DEATH

Month  
AugustDay  
23Year  
1960

## 5. SEX

Female

## 6. COLOR OR RACE

White

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒DIVORCED ☐

## 8. DATE OF BIRTH

2-5-86

## 9. AGE (In years last birthday) yrs.

74

## IF UNDER 1 YEAR

Months

Days

Hours

Min.

## 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

## 10b. KIND OF BUSINESS OR INDUSTRY

Home

## 11. BIRTHPLACE (State or foreign country)

Maryland

## 12. CITIZEN OF WHAT COUNTRY?

U.S.A.

## 13. FATHER'S NAME

Harry Sullivan

## 14. MOTHER'S MAIDEN NAME

Louisa Gibson

## 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

No

## 16. SOCIAL SECURITY NO.

4nd -

## INFORMANT

Hospital Records

## Address

## 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

DUE TO

ARTERIOSCLEROTIC Heart Disease  
CORONARY Arteriosclerosis  
Nephrosclerosis, chronic

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO

(c)

## INTERVAL BETWEEN ONSET AND DEATH

years  
years  
years

## PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

Chronic brain syndrome associated with circulatory disturbance, with cerebral arteriosclerosis, with psychotic reaction.

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

## 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year  
Hour o. m. p. m.20d. INJURY OCCURRED  
While at work ☐ Not while at work ☐

## 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

## 20f. (City or town)

## (County)

## (State)

21. I certify that I attended the deceased from 7-11, 1958, to 8-23, 1960, that I last saw the deceased alive on August 23, 1960, and that death occurred at 12 Noon, from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

## ACTUAL SIGNATURE

Ilse Kamm, M.D.

M.D.

Springfield State Hospital

8-23-60

## PHYSICIAN'S NAME (Type)

Ilse Kamm, M. D.

Sykesville, Maryland

## 22a. BURIAL, CREMATION, REMOVAL (Specify)

BURIAL

## 22b. DATE THEREOF

August 26, 1960

## 22c. NAME OF CEMETERY OR CREMATORY

Druid Ridge

## 22d. LOCATION (City, town, or county)

Pikesville, Baltimore

## (State)

## 23. FUNERAL DIRECTOR'S SIGNATURE

## ADDRESS

Arthur A. Haight, Sykesville, Md.

## 24a. REC'D BY REGISTRAR

AUG 29 '60

## 24b. REGISTRAR'S SIGNATURE

Orlinda S. Kline

1902

CERTIFICATE OF DEATH

1902

1902

1902

1902

1902

1902

1902

1902

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

8992

08963

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>4 mos. 3 days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 19</b>		d. STREET ADDRESS <b>1318 Forrest Road</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Alfred</b>		4. DATE OF DEATH Month <b>August</b> Day <b>4</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>September 9, 1872</b>
9. AGE (In years last birthday) <b>87</b> yrs.		IF UNDER 1 YEAR: Months <b>8</b> Days <b>7</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>Kentucky</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Hyron Evans</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>Springfield Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (b) <b>Bronchopneumonia</b> DUE TO (c) <b>422.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <b>Years</b> <b>Days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>C.B.S. assoc. with senile brain disease with psychotic reaction.</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>o. m.</b> <b>19</b> <b>p. m.</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>March 31, 1960</b> to <b>August 4, 1960</b> , that (I) (we) last saw the deceased alive on <b>August 4, 1960</b> , and that death occurred at <b>10:05 AM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Agustin del Campo</b>		22b. DATE SIGNED <b>8/4/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b>		22d. ADDRESS <b>Springfield Hospital, Sykesville, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>8-6-60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Connelly</b>		25a. REC'D BY REGISTRAR <b>Essex 21 md.</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles S. Hume</b>		DATE <b>AUG 8 '60</b>	

08303

STATE OF TEXAS

8335

County of *El Paso*  
State of *Texas*  
I, *John Doe*, Clerk of the County of *El Paso*, State of *Texas*, do hereby certify that the within and foregoing is a true and correct copy of the original as the same appears from the records of the County of *El Paso*, State of *Texas*, in Book of *Deeds*, Page *1234*.

Witness my hand and the seal of said County, at *El Paso*, this *10th* day of *January*, 19*12*.

*John Doe*  
Clerk of the County of *El Paso*, State of *Texas*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon top and bottom pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08964

8993

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Westminster 80 yds. N. Rural Westminster RD #4</u> c. LENGTH OF STAY IN 1b <u>80 yds.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Westminster RD #4</u> d. STREET ADDRESS <u>Leisters Church Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>JOHN</u> First <u>THOMAS</u> Middle <u>FORNEY</u> Last		4. DATE OF DEATH Month <u>Aug.</u> Day <u>30</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 5, 1880</u>
9. AGE (In years last birthday) <u>80</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Keysville, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George M. Forney</u>		14. MOTHER'S MAIDEN NAME <u>Isabelle Ohler</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mrs. John J. Forney, same address</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Recurrent Cerebral Thrombosis</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Smv.</u>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan. 60</u> to <u>Aug 30</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Aug. 30</u> , 19 <u>60</u> , and that death occurred at <u>12:45 p</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>M.C. Porterfield</u> M.D.		DATE SIGNED <u>8/31/61</u>	
PHYSICIAN'S NAME (Type) <u>M.C. Porterfield</u>		ADDRESS (Street, city or town, state) <u>HAMPSTEAD, MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept. 2, 60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Western Memorial</u>		22d. LOCATION (City, town, or county) (State) <u>Frederick, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Myers, Jr.</u> ADDRESS <u>Westminster, Md.</u>		24a. REC'D BY REGISTRAR <u>SEP 1 '60</u> DATE	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Haines</u>			

1884

CERTIFICATE OF DEATH

1884

*[Faint, illegible text, likely bleed-through from the reverse side of the page]*

1884



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8982

## CERTIFICATE OF DEATH

Reg. Dist. No.

08965

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>		c. LENGTH OF STAY IN 1b <u>75 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>148 W. Main St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>CHARLES RYLE</u> First Middle Last		4. DATE OF DEATH <u>August 2 1960</u> Month Day Year	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 20, 1873</u>
9. AGE (In years last birthday) <u>87</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Medical Doctor general practice Westminster Carroll Md.</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Foutz</u>		14. MOTHER'S MAIDEN NAME <u>Mary Riehlant</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Charles R. Foutz Jr; Westminster Md</u>	
17. INFORMANT <u>Charles R. Foutz Jr; Westminster Md</u>		Address <u>148 W. Main St.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic myocarditis</u> (c) <u>Arteriosclerosis + Emaciation</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1/2 hr</u> <u>several yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>August 1 1960</u> , to <u>Aug 2 1960</u> , that I last saw the deceased alive on <u>Aug 1 1960</u> , and that death occurred at <u>11:55 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William Speicher</u>		ADDRESS (Street, city or town, state) <u>Westminster Md</u>	
PHYSICIAN'S NAME (Type) <u>William Speicher</u>		DATE SIGNED <u>5/3/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug. 5, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Riverside Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Rural Westminster Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Mylek Jr; Westminster Md.</u>		ADDRESS <u>Westminster Md.</u>	
24a. REC'D BY REGISTRAR <u>Charles L. Kraus</u>		24b. REGISTRAR'S SIGNATURE <u>Charles L. Kraus</u>	
DATE <u>AUG 8 '60</u>			

CERTIFICATE OF DEATH

2385

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. DATE OF BIRTH <i>Jan 15 1880</i>		5. PLACE OF BIRTH <i>Baltimore, Md.</i>		6. OCCUPATION <i>Teacher</i>	
7. DATE OF DEATH <i>Jan 20 1925</i>		8. PLACE OF DEATH <i>Home</i>		9. CAUSE OF DEATH <i>Heart Disease</i>	
10. MEDICAL HISTORY <i>None</i>		11. PRESENT ILLNESS <i>None</i>		12. SIGNATURE OF PHYSICIAN <i>John Doe</i>	
13. SIGNATURE OF DECEASED <i>John Doe</i>		14. SIGNATURE OF WITNESS <i>John Doe</i>		15. SIGNATURE OF DECEASED <i>John Doe</i>	
16. SIGNATURE OF DECEASED <i>John Doe</i>		17. SIGNATURE OF DECEASED <i>John Doe</i>		18. SIGNATURE OF DECEASED <i>John Doe</i>	
19. SIGNATURE OF DECEASED <i>John Doe</i>		20. SIGNATURE OF DECEASED <i>John Doe</i>		21. SIGNATURE OF DECEASED <i>John Doe</i>	
22. SIGNATURE OF DECEASED <i>John Doe</i>		23. SIGNATURE OF DECEASED <i>John Doe</i>		24. SIGNATURE OF DECEASED <i>John Doe</i>	
25. SIGNATURE OF DECEASED <i>John Doe</i>		26. SIGNATURE OF DECEASED <i>John Doe</i>		27. SIGNATURE OF DECEASED <i>John Doe</i>	
28. SIGNATURE OF DECEASED <i>John Doe</i>		29. SIGNATURE OF DECEASED <i>John Doe</i>		30. SIGNATURE OF DECEASED <i>John Doe</i>	
31. SIGNATURE OF DECEASED <i>John Doe</i>		32. SIGNATURE OF DECEASED <i>John Doe</i>		33. SIGNATURE OF DECEASED <i>John Doe</i>	
34. SIGNATURE OF DECEASED <i>John Doe</i>		35. SIGNATURE OF DECEASED <i>John Doe</i>		36. SIGNATURE OF DECEASED <i>John Doe</i>	
37. SIGNATURE OF DECEASED <i>John Doe</i>		38. SIGNATURE OF DECEASED <i>John Doe</i>		39. SIGNATURE OF DECEASED <i>John Doe</i>	
40. SIGNATURE OF DECEASED <i>John Doe</i>		41. SIGNATURE OF DECEASED <i>John Doe</i>		42. SIGNATURE OF DECEASED <i>John Doe</i>	
43. SIGNATURE OF DECEASED <i>John Doe</i>		44. SIGNATURE OF DECEASED <i>John Doe</i>		45. SIGNATURE OF DECEASED <i>John Doe</i>	
46. SIGNATURE OF DECEASED <i>John Doe</i>		47. SIGNATURE OF DECEASED <i>John Doe</i>		48. SIGNATURE OF DECEASED <i>John Doe</i>	
49. SIGNATURE OF DECEASED <i>John Doe</i>		50. SIGNATURE OF DECEASED <i>John Doe</i>		51. SIGNATURE OF DECEASED <i>John Doe</i>	
52. SIGNATURE OF DECEASED <i>John Doe</i>		53. SIGNATURE OF DECEASED <i>John Doe</i>		54. SIGNATURE OF DECEASED <i>John Doe</i>	
55. SIGNATURE OF DECEASED <i>John Doe</i>		56. SIGNATURE OF DECEASED <i>John Doe</i>		57. SIGNATURE OF DECEASED <i>John Doe</i>	
58. SIGNATURE OF DECEASED <i>John Doe</i>		59. SIGNATURE OF DECEASED <i>John Doe</i>		60. SIGNATURE OF DECEASED <i>John Doe</i>	
61. SIGNATURE OF DECEASED <i>John Doe</i>		62. SIGNATURE OF DECEASED <i>John Doe</i>		63. SIGNATURE OF DECEASED <i>John Doe</i>	
64. SIGNATURE OF DECEASED <i>John Doe</i>		65. SIGNATURE OF DECEASED <i>John Doe</i>		66. SIGNATURE OF DECEASED <i>John Doe</i>	
67. SIGNATURE OF DECEASED <i>John Doe</i>		68. SIGNATURE OF DECEASED <i>John Doe</i>		69. SIGNATURE OF DECEASED <i>John Doe</i>	
70. SIGNATURE OF DECEASED <i>John Doe</i>		71. SIGNATURE OF DECEASED <i>John Doe</i>		72. SIGNATURE OF DECEASED <i>John Doe</i>	
73. SIGNATURE OF DECEASED <i>John Doe</i>		74. SIGNATURE OF DECEASED <i>John Doe</i>		75. SIGNATURE OF DECEASED <i>John Doe</i>	
76. SIGNATURE OF DECEASED <i>John Doe</i>		77. SIGNATURE OF DECEASED <i>John Doe</i>		78. SIGNATURE OF DECEASED <i>John Doe</i>	
79. SIGNATURE OF DECEASED <i>John Doe</i>		80. SIGNATURE OF DECEASED <i>John Doe</i>		81. SIGNATURE OF DECEASED <i>John Doe</i>	
82. SIGNATURE OF DECEASED <i>John Doe</i>		83. SIGNATURE OF DECEASED <i>John Doe</i>		84. SIGNATURE OF DECEASED <i>John Doe</i>	
85. SIGNATURE OF DECEASED <i>John Doe</i>		86. SIGNATURE OF DECEASED <i>John Doe</i>		87. SIGNATURE OF DECEASED <i>John Doe</i>	
88. SIGNATURE OF DECEASED <i>John Doe</i>		89. SIGNATURE OF DECEASED <i>John Doe</i>		90. SIGNATURE OF DECEASED <i>John Doe</i>	
91. SIGNATURE OF DECEASED <i>John Doe</i>		92. SIGNATURE OF DECEASED <i>John Doe</i>		93. SIGNATURE OF DECEASED <i>John Doe</i>	
94. SIGNATURE OF DECEASED <i>John Doe</i>		95. SIGNATURE OF DECEASED <i>John Doe</i>		96. SIGNATURE OF DECEASED <i>John Doe</i>	
97. SIGNATURE OF DECEASED <i>John Doe</i>		98. SIGNATURE OF DECEASED <i>John Doe</i>		99. SIGNATURE OF DECEASED <i>John Doe</i>	
100. SIGNATURE OF DECEASED <i>John Doe</i>		101. SIGNATURE OF DECEASED <i>John Doe</i>		102. SIGNATURE OF DECEASED <i>John Doe</i>	

TO BE FILLED BY THE DECEASED OR HIS NEAREST RELATIVE OR BY THE PHYSICIAN OR BY THE CLERK OF THE COURT OF RECORDS AND DEEDS.

## CERTIFICATE OF DEATH

08966

Reg. Dist. No.

8994

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Imbsbury Rt. #1</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Imbsbury Rt. #1</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Inner Road</u>				d. STREET ADDRESS <u>Inner Road</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM GERALD FRIZZELL</u>				4. DATE OF DEATH Month Day Year <u>AUG 17 1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec 12, 1924</u>	
9. AGE (In years last birthday) <u>35</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer &amp; employee of Black &amp; Decker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Yost Carroll Rd. U.S.A.</u>			
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>WILLIAM B. FRIZZELL</u>				14. MOTHER'S MAIDEN NAME <u>ELLA GERTRUDE GREEN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>215-26-1945</u>			
17. INFORMANT Address <u>Mr. W. Gerald Frizzell Imbsbury Md RT. 1</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 CORONARY THROMBOSIS</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>20 MINUTES</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>December, 1960</u> , to <u>August, 1960</u> , that I last saw the deceased alive on <u>August 17, 1960</u> , and that death occurred at <u>11:07 AM</u> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>19 RIDGE ROAD WESTMINSTER MARYLAND</u>				DATE SIGNED <u>8-17-60</u>			
ACTUAL SIGNATURE <u>Daniel I. Welliver</u> M.D.							
PHYSICIAN'S NAME (Type) <u>DANIEL I. WELLIVER</u>							
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/20/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Deer Park Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Rural Westminster Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Meyer, Jr. Westminster, Md.</u>				ADDRESS <u>Westminster, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 22 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

8995

68867

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Carroll</b> MARYLAND				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>1yr. 6mos. 9days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Springfield State Hospital</b>				j. STREET ADDRESS <b>12813 Matey Rd.</b>			
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <b>Mary Eloise Tonner Garvey</b>				<b>4. DATE OF DEATH</b> Month Day Year <b>August 8, 1960</b>			
<b>5. SEX</b> <b>Female</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>			
<b>8. DATE OF BIRTH</b> <b>July 26, 1918</b>		<b>9. AGE</b> (In years last birthday) <b>42</b> yrs.		<b>10. IF UNDER 1 YEAR</b> Months Days Hours Min.			
<b>11. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		<b>12. KIND OF BUSINESS OR INDUSTRY</b> <b>-</b>		<b>13. BIRTHPLACE</b> (State or foreign country) <b>Missouri</b>			
<b>14. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>		<b>15. FATHER'S NAME</b> <b>Michael Tonnar</b>					
<b>16. MOTHER'S MAIDEN NAME</b> <b>Clara Phister</b>				<b>17. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b>			
<b>18. SOCIAL SECURITY NO.</b> <b>-</b>		<b>19. INFORMANT</b> Address <b>Springfield Hospital Records</b>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Interstitial pneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) <b>Schizophrenic reaction, catatonic type.</b> DUE TO cause lost. (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Schizophrenic reaction, catatonic type.</b>							
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of Item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o. m. p. m. <b>19</b>		<b>20d. INJURY OCCURRED</b> White of work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town) (County) (State)</b>			
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input checked="" type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> <b>and in my opinion death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
<b>ACTUAL SIGNATURE</b> <b>James T. Marsh</b>		<b>EXAMINER'S NAME (Type)</b> <b>James T. Marsh, M.D.</b>		<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>22b. DATE THEREOF</b> <b>Aug. 11, 1960</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Arlington Natl. Cem. Arlington Va</b>			
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>H. Don, Jr.</b>		<b>24a. REC'D BY REGISTRAR</b> <b>DATE AUG 15 '60</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Kraus</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



(M)

STATE OF MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

80032

1. Name of deceased: John J. Smith

2. Sex: Male

3. Age: 45

4. Date of death: Aug 11, 1940

5. Place of death: Home

6. Cause of death: Myocardial infarction

7. Immediate cause: Coronary artery disease

8. Underlying cause: Arteriosclerosis

9. Contributing cause: None

10. Manner of death: Natural

11. Signature of Medical Examiner: [Signature]

12. Date of certification: Aug 12, 1940

13. Address of Medical Examiner: 1234 Main St, Baltimore, Md.

14. Name of Hospital: None

15. Name of Physician: Dr. J. H. Jones

16. Name of Coroner: John D. Doe

17. Name of Registrar: John D. Doe

18. Name of Undertaker: John D. Doe

19. Name of Burial Place: John D. Doe

20. Name of Funeral Home: John D. Doe

21. Name of Cemetery: John D. Doe

22. Name of Interment: John D. Doe

23. Name of Burial: John D. Doe

24. Name of Cremation: John D. Doe

25. Name of Disposition: John D. Doe

26. Name of Disposition: John D. Doe

27. Name of Disposition: John D. Doe

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99. Name of Disposition: John D. Doe

100. Name of Disposition: John D. Doe



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

8996

CERTIFICATE OF DEATH

Items 1, 2 Film 6270 9-6-60 et

08968

1. PLACE OF DEATH a. COUNTY <b>Carroll</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville - rural</b>		c. LENGTH OF STAY IN 1b <b>X Sykesville - rural</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Carroll</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Oakland Mill Rd.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>EDWARD</b> Middle <b>R.</b> Last <b>GISBURNE</b>		4. DATE OF DEATH Month <b>August</b> Day <b>28</b> Year <b>1960</b>					
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></b>	8. DATE OF BIRTH <b>Nov. 14, 1888</b>	9. AGE (In years last birthday) <b>71 yrs.</b>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Owner</b>		11. BIRTHPLACE (State or foreign country) <b>N. Y.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Owner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Trucking Co.</b>		11. BIRTHPLACE (State or foreign country) <b>N. Y.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>John Gisburne</b>				14. MOTHER'S MAIDEN NAME <b>unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mr. Edward H. Gisburne-380 S. Kenilworth Ave. Edinburg, Ill.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>EMBOLISM OF CORONARY ARTERY</b> <b>420.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b> DUE TO (c) <b>HYPERTENSIVE CARDIOVASCULAR DISEASE</b>						INTERVAL BETWEEN ONSET AND DEATH <b>20 min.</b> <b>15-20 yrs.</b> <b>40 plus yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1.9.60</b> to <b>8.28.60</b> , 19____, that (I) (we) last saw the deceased alive on <b>8.7.60</b> , 19____, and that death occurred at <b>10:30A</b> on the date stated above.							
22a. SIGNATURE <b>Wm. H. Lawson, Jr., M.D.</b>				22b. DATE SIGNED <b>8.28.60</b>		22c. PHYSICIAN'S NAME (Type) <b>Wm. H. Lawson, Jr., M.D.</b>	
22d. ADDRESS <b>Liberty Rd. nr Eldersburg, Sykesville, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE THEREOF <b>8/31/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Green Mount Crem.</b>		23d. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Chas. J. Lickner</b>				25a. REC'D BY REGISTRAR <b>Aug 30 '60</b>		25b. REGISTRAR'S SIGNATURE <b>C. L. S. Hanna</b>	

CHURCH OF THE BROTHERS

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DEPARTMENT OF HEALTH

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MASSACHUSETTS DEPARTMENT OF HEALTH  
BUREAU OF VITAL RECORDS  
BOSTON, MASS.  
JANUARY 1, 1900  
BIRTH RECORD  
Name: [illegible]  
Sex: [illegible]  
Age: [illegible]  
Date of Birth: [illegible]  
Place of Birth: [illegible]  
Parents: [illegible]  
Occupation: [illegible]  
Religion: [illegible]  
Marital Status: [illegible]  
Signature: [illegible]  
Date: [illegible]

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

8998

## CERTIFICATE OF DEATH

08970

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>4 mos. 3 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		e. STREET ADDRESS <b>2021 Osborn Drive</b>	
3. NAME OF DECEASED (Type or print) First <b>Harriet</b> Middle <b>Beulah</b> Last <b>Grier</b>		4. DATE OF DEATH Month <b>August</b> Day <b>4</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 6, 1887</b>
9. AGE (In years lost birthday) <b>73</b> yrs.		IF UNDER 1 YEAR Months <b>4</b> Days <b>1</b> Hours <b>160</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WILLIAM T. GRIER</b>		14. MOTHER'S MAIDEN NAME <b>Harriet Harkins</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>-----</b>	
17. INFORMANT <b>Springfield Hospital Records, Sykesville, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Confluent bronchopneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Metastatic carcinoma to the liver</b> DUE TO (c) <b>Carcinoma of the cecum</b>		INTERVAL BETWEEN ONSET AND DEATH <b>24 hours.</b> <b>Months</b> <b>Months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>CBS assoc. with senile brain disease, with psychotic reaction.</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>March 31, 1960</b> , to <b>August 4, 1960</b> , that (I) (we) last saw the deceased alive on <b>August 4, 1960</b> , and that death occurred at <b>4:10 A.M.</b> the causes and on the date stated above.			
22a. SIGNATURE <b>Agustin del Campo</b>		22b. DATE SIGNED <b>August 4, 1960</b>	
22c. PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b>		22d. ADDRESS <b>Springfield State Hosp., Sykesville, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8-6-60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Glenwood Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Washington Dc</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Deal Funeral Home</b>		24a. REC'D BY REGISTRAR <b>DATE AUG 9 '60</b>	
ADDRESS <b>4812 Ga Ave NW Dc</b>		25. REGISTRAR'S SIGNATURE <b>Arthur S. Hearn</b>	

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation or entombment, and in any event, within 72 hours after death.



8999

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

08971

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> <span style="float:right">MARYLAND</span>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Keymar</b>		c. LENGTH OF STAY IN lb <b>Lifetime</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Keymar</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Sharret Road</b>				d. STREET ADDRESS <b>Sharret Road</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Laura Virginia Hahn</b>			4. DATE OF DEATH Month <b>August</b> Day <b>11</b> Year <b>1960</b>				
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 4, 1877</b>		9. AGE (In years last birthday) <b>83</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Samuel Angell</b>				14. MOTHER'S MAIDEN NAME <b>Mary Brown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>212-40-5984</b>		17. INFORMANT Address <b>Miss Thelma Hahn, Keymar, Md.. R.D.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>422</b> IMMEDIATE CAUSE (a) <b>Chronic Myocarditis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>General debility</b> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b> <b>2 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 6, 1960</b> to <b>Aug 10, 1960</b> that (I) (we) last saw the deceased alive on <b>Aug 10, 1960</b> , and that death occurred at <b>2 AM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>J. N. Legg</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>Aug. 12, 1960</b>	
22c. PHYSICIAN'S NAME (Type) <b>T. H. LEGG MD</b>				22d. ADDRESS <b>Union Bridge Md</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Aug. 13, 1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Keysville Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Keysville, Carroll, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. E. Fuss &amp; Son,</b>				ADDRESS <b>Taneytown, Maryland</b>		25a. REC'D BY REGISTRAR DATE <b>AUG 15 '60</b>	
				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>			

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRINCE STREET, BALTIMORE 2, MARYLAND  
CERTIFICATE OF DEATH

1. NAME OF DECEASED  
2. SEX  
3. AGE  
4. DATE OF BIRTH  
5. PLACE OF BIRTH  
6. OCCUPATION  
7. MARITAL STATUS  
8. EDUCATION  
9. RELIGION  
10. RACE  
11. COLOR  
12. ETHNIC ORIGIN  
13. PLACE OF DEATH  
14. DATE OF DEATH  
15. TIME OF DEATH  
16. CAUSE OF DEATH  
17. MANNER OF DEATH  
18. SIGNATURE OF PHYSICIAN  
19. SIGNATURE OF REGISTRAR  
20. SIGNATURE OF WITNESS  
21. SIGNATURE OF DECEASED  
22. SIGNATURE OF NEXT OF KIN  
23. SIGNATURE OF OTHER

9000

## CERTIFICATE OF DEATH

08972

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Wash., D.C.</b> b. COUNTY <b>Prince George</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Henryton</b>		c. LENGTH OF STAY IN 1b <b>3 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Henryton State Hospital</b>		e. STREET ADDRESS <b>8720 Livingston Road</b>	
3. NAME OF DECEASED (Type or print) First <b>Lucy</b> Middle <b>Ford</b> Last <b>Johnson</b>		4. DATE OF DEATH Month <b>August</b> Day <b>24</b> Year <b>19 60</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <b>WIDOWED XX</b>	8. DATE OF BIRTH <b>5-29-1888</b>
9. AGE (In years last birthday) <b>72</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unemployed</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Brandywine, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Joseph Ford</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Mamie Miller- 8720 Livingston Rd. Wash., D.C.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>002X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Part II <b>Cardiovascular arteriosclerosis</b> <b>005-10</b> (c) <b>Moderately advanced pulmonary tuberculosis</b>			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>August 22, 1960</b> to <b>August 24, 1960</b> , that (I) (we) last saw the deceased alive on <b>Aug. 24, 1960</b> and that death occurred at <b>6:35 p.m.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Dr. Edgars M. Maculans, Supt.</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Edgars M. Maculans</b>		22d. ADDRESS <b>Henryton, Maryland</b>	
23a. BURIAL, CREMATION, RESURROVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>8-28-60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Church</b>		23d. LOCATION (City, town, or county) (State) <b>CHAPEL HILL MARYLAND</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>John T. Rhine Co.</b>		25a. REC'D BY REGISTRAR <b>DATE AUG 30 '60</b>	
ADDRESS <b>3015-12th St. N.E. D.C.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kane</b>	

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 7, MARYLAND  
CERTIFICATE OF DEATH

1. NAME OF DECEASED  
2. SEX  
3. AGE  
4. DATE OF BIRTH  
5. PLACE OF BIRTH  
6. OCCUPATION  
7. MARITAL STATUS  
8. RACE  
9. COLOR  
10. RELIGION  
11. EDUCATION  
12. PLACE OF DEATH  
13. DATE OF DEATH  
14. TIME OF DEATH  
15. CAUSE OF DEATH  
16. MANNER OF DEATH  
17. SIGNATURE OF PHYSICIAN  
18. SIGNATURE OF REGISTRAR  
19. SIGNATURE OF WITNESSES  
20. SIGNATURE OF DECEASED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 9001 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08973

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Carroll</b> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b> c. LENGTH OF STAY IN 1b <b>25yrs. 10mos. 5 days</b> <span style="float: right;">Baltimore</span> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Springfield State Hospital</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> <span style="float: right;">b. COUNTY <b>Balto. City</b></span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>630 Cokesbury Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Charles</b> Middle <b>Killmon</b> Last <b>Killmon</b>				<b>4. DATE OF DEATH</b> Month <b>August</b> Day <b>9</b> Year <b>19 60</b>											
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>July 9, 1899</b>		<b>9. AGE</b> (In years last birthday) <b>61</b> yrs.		<b>IF UNDER 1 YEAR</b> Months <b>0</b> Days <b>0</b>		<b>IF UNDER 24 HRS.</b> Hours <b>0</b> Min. <b>0</b>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>None</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>None</b>				<b>11. BIRTHPLACE</b> (State or foreign country) <b>Maryland</b>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>			
<b>13. FATHER'S NAME</b> <b>Charles W. Killmon</b>								<b>14. MOTHER'S MAIDEN NAME</b> <b>Elizabeth A. White</b>							
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b>				<b>16. SOCIAL SECURITY NO.</b> <b>-</b>				<b>17. INFORMANT</b> Address <b>Springfield Hospital Records</b>							
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b> DUE TO (b) <b>Due to Coronary arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>years</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Schizophrenic reaction, paranoid type.</b>												INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b>			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>															
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> [Enter nature of injury in Part I or Part II of item 18.]											
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <b>a. m.</b> <b>p. m.</b> <b>19</b>				<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)							
<b>21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from:</b> Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .															
<b>ACTUAL SIGNATURE</b> <i>James T. Marsh</i> <b>M.D.</b> <b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DATE SIGNED</b> <b>EXAMINER'S NAME (Type)</b> <b>James T. Marsh, M.D.</b> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <b>8/10/60</b>															
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>				<b>22b. DATE THEREOF</b> <b>8-18-60</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Springfield Hospital</b>				<b>22d. LOCATION</b> (City, town, or county) (State) <b>Sykesville, Carroll, Md.</b>					
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <i>Arthur H. Knight</i>						<b>ADDRESS</b> <b>Sykesville, Md.</b>		<b>24a. REC'D BY REGISTRAR</b> <b>DATE</b> <b>AUG 23 '60</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <i>Robert S. Kneale</i>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your own files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with  
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

9002  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
Item 1 Film 0270 9-5-60 et

08974

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>2 Mos. 16 Days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>William Edward Little</b>		4. DATE OF DEATH <b>8 26 1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/17/90</b>
9. AGE (In years last birthday) <b>70</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Racetrack guard</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>?</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth O. ?</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>218225872</b>	
17. INFORMANT <b>Springfield State Hospital Record</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>424</b> IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> DUE TO <b>Bilateral Pneumonia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>C.B.S. associated with Senile Brain Disease</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <b>8 26 1960</b> Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>6/10/1960</b> to <b>8/26/1960</b> , that (I) (we) last saw the deceased alive on <b>8/26 1960</b> , and that death occurred at <b>5:45p</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Agustin del Campo</b> M.D.		22b. DATE SIGNED <b>8/26/1960</b>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>8-29-60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Leonard J. Ruck</b>		25a. REC'D BY REGISTRAR <b>AUG 30 '60</b>	
ADDRESS <b>5305 Harford Rd.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kne...</b>	

15013

CERTIFICATE OF BIRTH

0002



*[The following text is extremely faint and largely illegible due to the quality of the scan. It appears to be a standard birth certificate form with fields for name, date, and location.]*

NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

PLACE OF BIRTH: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

9003

## CERTIFICATE OF DEATH

Reg. Dist. No. 08975

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hampstead Road</u>		c. LENGTH OF STAY IN 1b <u>5 yrs</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hampstead (Rural)</u>		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>METTIE</u> - J - Middle <u>LUDWIG</u> Last		4. DATE OF DEATH Month <u>Aug</u> Day <u>28</u> Year <u>1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 30 - 1877</u>
9. AGE (In years last birthday) <u>83</u>		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Edmund Reed</u>	
14. MOTHER'S MAIDEN NAME <u>Catherine Smith</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT <u>Bert Croft, Hampstead Rd</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Antenocardiac Heart Disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Antenocardiac Generalized</u> DUE TO (c) <u>5 yrs</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>6P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>W. H. Foard</u> M.D. <u>Manchester, Md</u> <u>8-29-60</u> ACTUAL SIGNATURE <u>W. H. Foard M.D.</u> <u>Manchester, Md</u> PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>8-31-60</u>	<u>Manchester</u>	<u>Carroll Co Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edw E. Gipton - Hampstead Md</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 1 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneass</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

0007



CERTIFICATE OF TRADE



*[Faint, mostly illegible text, likely bleed-through from the reverse side of the page. Some words like 'TRADE' and 'CERTIFICATE' are visible.]*

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**RURAL STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

08976

9004

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b></b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Sykesville</b>				c. LENGTH OF STAY IN 1b <b>5y. 3m. 1d.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Mamie</b> Middle <b>Josephine</b> Last <b>Martin</b>				4. DATE OF DEATH Month <b>8</b> Day <b>19</b> Year <b>1960</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8/3/78</b>		9. AGE (In years last birthday) <b>82</b> yrs.	10. IF UNDER 1 YEAR Months <b></b> Days <b></b> Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Decorator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Interior decorator</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Alexander T. Martin</b>				14. MOTHER'S MAIDEN NAME <b>Mary Wilson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b></b>		17. INFORMANT Address <b>Springfield Hospital records, Sykesville, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic cardio-vascular disease</b> DUE TO (c) <b></b>							INTERVAL BETWEEN ONSET AND DEATH Hours <b></b> Years <b></b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>CBS assoc. with disturbance of metabolism, growth or nutrition, with</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>senile brain disease</b>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b></b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>5/18/1955</b> to <b>8/19/1960</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>8/19/1960</b> , and that death occurred at <b>8:35 AM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <i>Konstantin Weber</i>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>8/19/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Konstantin Weber, M. D.</b>				22d. ADDRESS <b>Sykesville, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8/22/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Trinity Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>St. Mary's City, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. CLARKE MATTINGLEY</b>				ADDRESS <b>LEONARDTOWN, MARYLAND</b>		25a. REC'D BY REGISTRAR DATE <b>AUG 23 '60</b>	
				25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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**MARYLAND STATE BOARD OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

9005

08977

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural--Eldersburg</b>				c. LENGTH OF STAY IN 1b <b>11 yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Liberty Rd., P.O. Sykesville</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>ROBERT</b> First <b>GEORGE</b> Middle <b>MILLER</b> Last				4. DATE OF DEATH <b>August</b> Month <b>4,</b> Day <b>19</b> Year <b>60</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>January 12, 1877</b>	
9. AGE (In years last birthday) <b>83</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>				10b. KIND OF INDEX OR INDUSTRY <b>Visible Equipt.</b>			
11. BIRTHPLACE (State or foreign country) <b>England</b>				12. CITIZEN OF WHAT COUNTRY? <b>England</b> ✓			
13. FATHER'S NAME <b>Harry Miller</b>				14. MOTHER'S MAIDEN NAME <b>Mary P. Harding</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) -----				16. SOCIAL SECURITY NO. <b>577-09-9519</b>			
17. INFORMANT <b>Mr. Clarence C. Carty, Frederick, Md</b>				Address <b>54 E. Patrick</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>332X</b> DUE TO <b>Cerebral Thrombosis, left hemisphere</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <b>Arteriosclerosis generalized, conclusive</b> DUE TO <b>pneumonia, pneumonia -</b> INTERVAL BETWEEN ONSET AND DEATH <b>July 60 to 4 Aug 60</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>21 July 1960</b> to <b>4 Aug 60</b> , that (I) (we) last saw the deceased alive on <b>4 Aug 1960</b> , and that death occurred at <b>4 Aug 60</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>Howard E. Hall</b>				22b. DATE SIGNED <b>4 Aug 60</b>			
22c. PHYSICIAN'S NAME (Type) <b>Howard E. Hall M. D.</b>				22d. ADDRESS <b>Sperryville, Md.</b>			
23a. BURIAL, CREMATION, or other disposition (Specify) <b>Burial</b>				23b. DATE THEREOF <b>Aug. 6, 1960</b>			
23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>				23d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>C. M. Waltz, Winfield, Maryland</b>				25a. REC'D BY REGISTRAR <b>AUG 8 '60</b>			
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kram</b>							

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9006

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Union Bridge Rural</u>				c. LENGTH OF STAY IN 1b <u>1 yr</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>STELLA</u> First <u>MAE</u> Middle <u>MINNIE</u> Last <u>K</u>				4. DATE OF DEATH <u>Aug 2</u> Month <u>Aug</u> Day <u>2</u> Year <u>1960</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov 8-1897</u>	
9. AGE (In years last birthday) <u>62</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Richard F. Robinson</u>				14. MOTHER'S MAIDEN NAME <u>Rosa F. Ravenscroft</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>214-16-2398</u>			
17. INFORMANT <u>Mrs Fred Spalla</u> Address <u>Union Bridge Md</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatous</u> 174X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Original site - uterus</u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11/5/59</u> , 19 <u>59</u> , to <u>8/2/60</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>7/31/60</u> , 19 <u>60</u> , and that death occurred at <u>1:40 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>M. E. Robertson</u>				ADDRESS (Street, city or town, state) <u>New Windsor, Md</u> DATE SIGNED <u>8/2/60</u>			
PHYSICIAN'S NAME (Type) <u></u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug 5-1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Pipe Creek</u>		22d. LOCATION (City, town, or county) (State) <u>Carroll Co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edw E. Tipton</u> ADDRESS <u>Hampstead Md</u>				24a. REC'D BY REGISTRAR <u>Aug 4 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove urban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9008

CERTIFICATE OF DEATH

10318

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8983

## CERTIFICATE OF DEATH

08979

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>CARROLL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>23 PARK AVE.</u>				d. STREET ADDRESS <u>23 PARK AVE</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARY VIRGINIA MOONEY</u>				4. DATE OF DEATH Month Day Year <u>Aug 6 1960</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>OCT. 3 1895</u>		9. AGE (In years last birthday) <u>64</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SCHOOL TEACHER.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PUBLIC SCHOOL</u>		11. BIRTHPLACE (State or foreign country) <u>EASTON, PENNA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN MOONEY</u>				14. MOTHER'S MAIDEN NAME <u>NORA AMBROSE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>208-26-8750</u>		17. INFORMANT Address <u>MRS. EDWIN K. WADE, WESTMINSTER MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CA RECTUM-PERITONEAL METASTASIS</u> <u>154X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>1 yr -</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8-19</u> , 19 <u>59</u> , to <u>8-6</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>8-6</u> , 19 <u>60</u> , and that death occurred at <u>10 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James T. Marsh</u> M.D.				ADDRESS (Street, city or town, state) <u>105E MAIN ST WESTMINSTER MD</u>		DATE SIGNED <u>8-6-60</u>	
PHYSICIAN'S NAME (Type) <u>JAMES T. MARSH.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>AUG 10, 60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>GETHSEMANE CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>EASTON PENNA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. S. Myers, Jr. Westminister, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>AUG 9 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hearn</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male	
3. AGE 65		4. DATE OF BIRTH 1885	
5. PLACE OF BIRTH BALTIMORE, MARYLAND		6. OCCUPATION Carpenter	
7. MARITAL STATUS Married		8. DATE OF MARRIAGE 1910	
9. NAME OF SPOUSE Mary H. Harris		10. DATE OF DEATH 1950	
11. PLACE OF DEATH Home		12. CAUSE OF DEATH Heart Disease	
13. MEDICAL HISTORY Hypertension, Atherosclerosis		14. PRESENT ILLNESS Myocardial Infarction	
15. PHYSICIAN'S SIGNATURE Dr. J. H. Smith		16. PLACE OF INTERMENT Catholic Cemetery	
17. SIGNATURE OF NEXT OF KIN John H. Harris		18. SIGNATURE OF DECEASED (if living)	
19. SIGNATURE OF WITNESSES John H. Harris, Mary H. Harris		20. SIGNATURE OF REGISTRAR John H. Harris	

1. NAME OF DECEASED  
JAMES H. HARRIS

2. SEX  
Male

3. AGE  
65

4. DATE OF BIRTH  
1885

5. PLACE OF BIRTH  
BALTIMORE, MARYLAND

6. OCCUPATION  
Carpenter

7. MARITAL STATUS  
Married

8. DATE OF MARRIAGE  
1910

9. NAME OF SPOUSE  
Mary H. Harris

10. DATE OF DEATH  
1950

11. PLACE OF DEATH  
Home

12. CAUSE OF DEATH  
Heart Disease

13. MEDICAL HISTORY  
Hypertension, Atherosclerosis

14. PRESENT ILLNESS  
Myocardial Infarction

15. PHYSICIAN'S SIGNATURE  
Dr. J. H. Smith

16. PLACE OF INTERMENT  
Catholic Cemetery

17. SIGNATURE OF NEXT OF KIN  
John H. Harris

18. SIGNATURE OF DECEASED  
(if living)

19. SIGNATURE OF WITNESSES  
John H. Harris, Mary H. Harris

20. SIGNATURE OF REGISTRAR  
John H. Harris



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
9007 Items 7 Film G271 9-14-60 et  
CERTIFICATE OF DEATH

18980

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> Maryland MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>(Rural) Sykesville</b>		c. LENGTH OF STAY IN lb <b>7yr. 9mo. 07d.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		d. STREET ADDRESS <b>954 LaVale St.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Earl</b> First <b>Upton</b> Middle <b>Myers</b> Last		4. DATE OF DEATH Month <b>8</b> Day <b>28</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-7-02</b>
9. AGE (In years last birthday) <b>58</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Railroad blacksmith</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>railroad</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland, Hagerstown</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Daniel Myers</b>		14. MOTHER'S MAIDEN NAME <del>DESSIE</del> <b>Dessie Johns</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>unknown no</b>		16. SOCIAL SECURITY NO. <b>705-10-6598</b>	
17. INFORMANT <b>Records Springfield State Hospital</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Meningoencephalitis</b> 340.3 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Brain Syndrome associated with central nervous system syphilis, meningo-encephalitis with psychotic reaction.</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>years</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ---	
20c. TIME OF INJURY Month, Day, Year Hour o. m. --- 19 p. m. ---		20d. INJURY OCCURRED While Not while of work <input checked="" type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ---		20f. (City or town) (County) (State) ---	
21. I certify that I attended the deceased from <b>7-1957</b> , 19 <b>Aug. 28</b> , 19 <b>60</b> that I last saw the deceased alive on <b>Aug. 28</b> , 19 <b>60</b> , and that death occurred at <b>8:25</b> P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b> DATE SIGNED <b>8-28-60</b>			
ACTUAL SIGNATURE <b>Yasuo Takahashi</b> M.D.		PHYSICIAN'S NAME (Type) <b>Yasuo Takahashi, M.D.</b> <b>Sykesville, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>8-31-60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son, Hagerstown, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 31 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>			

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10  
9002  
CERTIFICATE OF DEATH

at nervous system  
the reaction.

Aug. 28  
p

8:25

Springfield

Sykesville

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

1  
4

9008

CERTIFICATE OF DEATH

08981

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto. County</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN lb <b>8 months 21 days Baltimore</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		d. STREET ADDRESS <b>2914 North Wind Road</b>	
3. NAME OF DECEASED (Type or print) <b>Charles</b> First <b>Frederick</b> Middle <b>Neubert</b> Last		4. DATE OF DEATH Month <b>8</b> Day <b>27</b> Year <b>1960</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-7-1878</b>
9. AGE (In years lost birthday) <b>82</b> yrs.		10. IF UNDER 1 YEAR Months _____ Days _____	11. IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>PAPER BOX CO.</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>LUDWIG NEUBERT</b>		14. MOTHER'S MAIDEN NAME <b>CAROLINE MEINERT</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-10-3026</b>	
17. INFORMANT <b>Springfield Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Suppurative bilateral Nephritis</b> DUE TO <b>420.0</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>CBS assoc. with cerebral arteriosclerosis, with psychotic reaction</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>Months</b> <b>Years</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>11-6-59</b> 19____, to <b>8-27-</b> 19 <b>60</b> , that (I) (we) last saw the deceased alive on <b>8-27</b> 19 <b>60</b> , and that death occurred at <b>2:45 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Agustin del Campo</b>		22b. DATE <b>8/27/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Agustin Del Campo</b>		22d. ADDRESS <b>Springfield Hospital, Sykesville, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>8/31/60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>PARKWOOD CEM</b>		23d. LOCATION (City, town, or county) (State) <b>BALTO CO MD</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Chas F. Evans &amp; Son</b>		25a. REC'D BY REGISTRAR <b>DATE AUG 31 '60</b>	
ADDRESS <b>8802 HARTFORD RD</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Evans</b>	

12990

CERTIFICATE OF DEATH

9008



I hereby certify that the within and foregoing is a true and correct copy of the original as the same appears in the records of the Registrar of the County of [illegible] State of [illegible]

Witness my hand and the seal of said County at [illegible] this [illegible] day of [illegible] 19[illegible]

Registrar of the County of [illegible] State of [illegible]

Attest my hand and the seal of said County at [illegible] this [illegible] day of [illegible] 19[illegible]

County Clerk of the County of [illegible] State of [illegible]

Subscribed and sworn to before me this [illegible] day of [illegible] 19[illegible]

Notary Public for the State of [illegible]

My commission expires on the [illegible] day of [illegible] 19[illegible]

Notary Public for the State of [illegible]

My commission expires on the [illegible] day of [illegible] 19[illegible]

Notary Public for the State of [illegible]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
9009 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08982

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>JYKESVILLE</u>		c. LENGTH OF STAY IN 1b <u>16 days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>R.F.D.1 Knoxville</u>		<u>10X-2</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SPRINGFIELD STATE HOSPITAL</u>		d. STREET ADDRESS <u>Petersville Road</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>CORINE SHANK ORNDORFF</u>		4. DATE OF DEATH Month Day Year <u>8 20 1960</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>8-25-1902</u>
9. AGE (In years last birthday) <u>57</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min. <u>11 25</u>	IF UNDER 24 HRS. <u>11 25</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CHARLES E SHANK</u>		14. MOTHER'S MAIDEN NAME <u>CLARA BELL MUMMERT</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>HOSPITAL RECORDS</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RHEUMATIC OR MITRAL HEART DISEASE</u> <u>410X</u> DUE TO <u>PULMONARY EDEMA</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>INSULIN SHOCK</u> DUE TO (c) <u>DIABETES MELLITUS</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>DIABETES MELLITUS</u> INTERVAL BETWEEN ONSET AND DEATH <u>YEARS</u> <u>HOURS</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>James J. Marsh</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-23-1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Forest Heights</u>		22d. LOCATION (City, town, or county) (State) <u>Brunswick Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>P. Lee Foster Brunswick Md</u>		ADDRESS	
24a. REC'D BY REGISTRAR <u>8-21-60</u>		24b. REGISTRAR'S SIGNATURE <u>August 26 '60</u>	

STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age	
4. Date of death		5. Time of death		6. Place of death	
7. Cause of death		8. Manner of death		9. Signature of medical examiner	
10. Signature of attending physician		11. Signature of coroner		12. Signature of registrar	
13. Signature of medical examiner		14. Signature of coroner		15. Signature of registrar	
16. Signature of medical examiner		17. Signature of coroner		18. Signature of registrar	
19. Signature of medical examiner		20. Signature of coroner		21. Signature of registrar	
22. Signature of medical examiner		23. Signature of coroner		24. Signature of registrar	
25. Signature of medical examiner		26. Signature of coroner		27. Signature of registrar	
28. Signature of medical examiner		29. Signature of coroner		30. Signature of registrar	
31. Signature of medical examiner		32. Signature of coroner		33. Signature of registrar	
34. Signature of medical examiner		35. Signature of coroner		36. Signature of registrar	
37. Signature of medical examiner		38. Signature of coroner		39. Signature of registrar	
40. Signature of medical examiner		41. Signature of coroner		42. Signature of registrar	
43. Signature of medical examiner		44. Signature of coroner		45. Signature of registrar	
46. Signature of medical examiner		47. Signature of coroner		48. Signature of registrar	
49. Signature of medical examiner		50. Signature of coroner		51. Signature of registrar	
52. Signature of medical examiner		53. Signature of coroner		54. Signature of registrar	
55. Signature of medical examiner		56. Signature of coroner		57. Signature of registrar	
58. Signature of medical examiner		59. Signature of coroner		60. Signature of registrar	
61. Signature of medical examiner		62. Signature of coroner		63. Signature of registrar	
64. Signature of medical examiner		65. Signature of coroner		66. Signature of registrar	
67. Signature of medical examiner		68. Signature of coroner		69. Signature of registrar	
70. Signature of medical examiner		71. Signature of coroner		72. Signature of registrar	
73. Signature of medical examiner		74. Signature of coroner		75. Signature of registrar	
76. Signature of medical examiner		77. Signature of coroner		78. Signature of registrar	
79. Signature of medical examiner		80. Signature of coroner		81. Signature of registrar	
82. Signature of medical examiner		83. Signature of coroner		84. Signature of registrar	
85. Signature of medical examiner		86. Signature of coroner		87. Signature of registrar	
88. Signature of medical examiner		89. Signature of coroner		90. Signature of registrar	
91. Signature of medical examiner		92. Signature of coroner		93. Signature of registrar	
94. Signature of medical examiner		95. Signature of coroner		96. Signature of registrar	
97. Signature of medical examiner		98. Signature of coroner		99. Signature of registrar	
100. Signature of medical examiner		101. Signature of coroner		102. Signature of registrar	

1



9010

## CERTIFICATE OF DEATH

68983

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Carroll Co</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Westminster 56 yrs</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Westminster, Md.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Westminster Md RD #2</u>				d. STREET ADDRESS <u>New Windsor Road</u>		6. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ALICE</u> Middle <u>ADELINE</u> Last <u>PELTZ</u>			4. DATE OF DEATH Month <u>AUGUST</u> Day <u>28</u> Year <u>1960</u>				
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC. 27, 1903</u>		9. AGE (In years last birthday) <u>56</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>ELWOOD E. SNADER</u>				14. MOTHER'S MAIDEN NAME <u>FLORENCE B. NUSBAUM</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>212-24-540</u>		17. INFORMANT <u>HUSBAND-Charles W. Peltz</u> Address <u>Sage</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ADENOCARCINOMA OF THE OVARY</u> <u>175.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>16 MOS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>DEC. 14, 1959</u> to <u>AUG. 28, 1960</u> , that I last saw the deceased alive on <u>AUG. 28, 1960</u> , and that death occurred at <u>120 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>19 RIDGE RD. WESTMINSTER, MD.</u> DATE SIGNED <u>AUG. 28, 1960</u>							
ACTUAL SIGNATURE <u>William Lewis Stewart, M.D.</u>				PHYSICIAN'S NAME (Type) <u>WILLIAM LEWIS STEWART WESTMINSTER, MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial Aug. 31 '60</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Winters Cemetery Rural New Windsor Md</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Meyer, Jr., Westminster Md</u>				24a. REC'D BY REGISTRAR DATE <u>SEP 1 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1011

<p>NAME OF DECEASED <i>John Doe</i></p>		<p>DATE OF DEATH <i>10/11/1911</i></p>	
<p>PLACE OF DEATH <i>Home</i></p>		<p>CAUSE OF DEATH <i>Heart Disease</i></p>	
<p>AGE <i>45</i></p>		<p>SEX <i>Male</i></p>	
<p>BIRTH DATE <i>1866</i></p>		<p>BIRTH PLACE <i>Maryland</i></p>	
<p>EDUCATION <i>High School</i></p>		<p>OCCUPATION <i>Teacher</i></p>	
<p>RELIGION <i>Methodist</i></p>		<p>PREVIOUS ILLNESS <i>None</i></p>	
<p>DATE OF BURIAL <i>10/13/1911</i></p>		<p>PLACE OF BURIAL <i>Cemetery</i></p>	
<p>SIGNATURE OF DECEASED <i>John Doe</i></p>		<p>SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>SIGNATURE OF PHYSICIAN <i>John Doe</i></p>		<p>SIGNATURE OF CORONER <i>John Doe</i></p>	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND HEALTH DEPARTMENT.

1  
 MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
 CERTIFICATE OF DEATH

08984

9011

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. LENGTH OF STAY IN 1b <b>5mos. 3days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				d. STREET ADDRESS <b>Route #1</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Virginia</b> Last <b>Hatfield Porter</b>				4. DATE OF DEATH Month <b>August</b> Day <b>21</b> Year <b>1960</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>October 4, 1884</b>	
9. AGE (In years last birthday) <b>75</b> yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>		IF UNDER 24 HRS. Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
3. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Amelia Porter</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT <b>Springfield Hospital Records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>491X</b> IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the <u>under-</u> lying cause lost. (b) <input type="checkbox"/> DUE TO (c) <input type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH <b>Days</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>C.B.S. assoc. with senile brain disease with psychotic reaction.</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <input type="checkbox"/> p. m. <input type="checkbox"/> <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>March 18, 1960</b>				20g. (County) <b>August 21, 1960</b>			
20h. (State) <b>that (I) (we) last saw the deceased alive on August 21, 1960, and that death occurred at 6:30 P.M. from the causes and on the date stated above.</b>							
22a. SIGNATURE <b>Agustin del Campo</b>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>8/22/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b>				22d. ADDRESS <b>Springfield Hospital, Sykesville, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Aug. 24, 1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Taylorville Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Carroll Co., Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>C. M. Waltz, Winfield, Maryland</b>				25a. REC'D BY REGISTRAR <b>AUG 24 60</b>		25b. REGISTRAR'S SIGNATURE <b>C. M. Waltz</b>	

0001, 25. 1960

9012  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

08385

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Middleburg</u>				c. LENGTH OF STAY IN 1b <u>5 months</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brookfield Manor Nursing Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Isaiah</u> Middle <u>Lewis</u> Last <u>Reifsnider</u>				4. DATE OF DEATH Month <u>August</u> Day <u>13</u> Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 3, 1872</u>	
9. AGE (In years last birthday) <u>88</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Isaiah William Reifsnider</u>				14. MOTHER'S MAIDEN NAME <u>Rebecca Lippy</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Mr. Raymond Reifsnider, Hanover, Pennsylvania</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myocarditis and Myocardial Degeneration</u> DUE TO (b) <u>Coronary Arteriosclerosis</u> DUE TO (c) <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				INTERVAL BETWEEN ONSET AND DEATH <u>15 yrs.</u> <u>15 yrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized Arteriosclerosis, Chronic Cystitis &amp; Prostatitis</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>11/17/41</u> 19 <u>  </u> to <u>8/13/60</u> 19 <u>  </u> , that (I) (we) last saw the deceased alive on <u>8/13/60</u> 19 <u>  </u> , and that death occurred at <u>7 A.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>R. S. McVaugh</u>				22b. DATE SIGNED <u>AUG. 15, 1960</u>		22c. PHYSICIAN'S NAME (Type) <u>R. S. McVaugh</u>	
22d. ADDRESS <u>Taneytown, Md.</u>				22e. REC'D BY REGISTRAR <u>Arthur S. Thraus</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Aug. 16, 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Reformed Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Taneytown, Carroll, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>C. O. Fuss &amp; Son</u>				25a. REC'D BY REGISTRAR <u>DATE AUG 17 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thraus</u>	

05/18/55

CERTIFICATE OF DEATH

2012

(M)

(1)

*Handwritten text, likely a signature or name, appearing upside down.*

8/13/50

11/13/51

8/13/50

*Handwritten signature or name.*

*Handwritten signature or name.*



9015

## CERTIFICATE OF DEATH

08988

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Westminster, Md.</b>		c. LENGTH OF STAY IN 1b <b>43 Yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION -----		d. STREET ADDRESS <b>R.D.#6 Westminster, Md.</b>	
3. NAME OF DECEASED (Type or print) <b>William Edward Sitterding</b>		4. DATE OF DEATH Month <b>Aug.</b> Day <b>13</b> Year <b>19 60</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/31/1883</b>
9. AGE (In years last birthday) <b>77</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>poultry</b>	
11. BIRTHPLACE (State or foreign country) <b>Balto. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John William Sitterding</b>		14. MOTHER'S MAIDEN NAME <b>Louise Besser</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>220-34-7076</b>	
17. INFORMANT <b>son Mr. Edward G. Sitterding</b>		Address <b>R.D.#6 Westminster, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cerebral hemorrhage</b> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Vascular disease</b> DUE TO (c) <b>senility</b> INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>5 years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>none</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Aug. 12</b> , 19 <b>55</b> , to <b>Aug. 13</b> , 19 <b>60</b> that I last saw the deceased alive on <b>Aug. 12</b> , 19 <b>60</b> , and that death occurred at <b>6:30</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Westminster, Md.</b> DATE SIGNED <b>8-13-60</b>			
ACTUAL SIGNATURE <b>C. L. Billingslea</b>		M.D. <b>Westminster, Md.</b>	
PHYSICIAN'S NAME (Type) <b>Dr. C. L. Billingslea</b>		I S. Center St. Westminster, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>8/16/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Deer Park Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Smallwood Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James L. Saffell Jr.</b>		ADDRESS <b>Westminster, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>AUG 16 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

2012

CERTIFICATE OF DEATH

County

Residence

Married

John - Westchester, N.Y. 62 yrs. Rural - Westchester, N.Y.

H.P. Westchester, N.Y.

Residence

John

John

5/21/1988

County

John

John Westchester

John Westchester

220-44-7076 son of Edward J. Westchester

son

[Faint, mostly illegible text in the middle section of the document]

John J. Westchester, N.Y. son of Edward J. Westchester, N.Y.

John J. Westchester, N.Y. son of Edward J. Westchester, N.Y.

John J. Westchester, N.Y.

Westchester, N.Y.

[Handwritten signature and notes at the bottom right]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

9013

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

08386

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Taneytown</b>		c. LENGTH OF STAY IN 1b <b>60 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Taneytown</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Samuel</b> Middle <b>David</b> Last <b>Snider</b>				4. DATE OF DEATH Month <b>August</b> Day <b>21</b> Year <b>19 60</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 4, 1874</b>		9. AGE (In years last birthday) <b>86</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Day Labor</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William A. Snider</b>				14. MOTHER'S MAIDEN NAME <b>Alice Bower</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Mrs. Carl Baumgardner, Littlestown, Penna.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>420.1</b> IMMEDIATE CAUSE (a) <b>Acute Coronary Thrombosis</b> DUE TO <b>Arteriosclerotic Cardio-Vascular Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>5 min.</b> <b>10 years</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>8/24</b> 19 <b>60</b> to <b>8/21</b> 19 <b>60</b> , that (I) (we) last saw the deceased alive on <b>8/15</b> 19 <b>60</b> , and that death occurred at <b>11:00 P.</b> M. from the causes and on the date stated above.							
22a. SIGNATURE <b>R. R. Potter</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>8/22/60</b>			
22c. PHYSICIAN'S NAME (Type) <b>L. L. POTTER M.D.</b>		22d. ADDRESS <b>LITTLESTOWN, PA.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Aug. 24, 1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Harney Lutheran Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Harney, Carroll, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Merwyn C. Fuss</b> <b>C. O. Fuss &amp; Son,</b>				ADDRESS <b>Taneytown, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>AUG 25 '60</b>	
				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>			



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9014 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 9 FilmG269 8-17-60 et

Reg. Dist. No.

08987

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto. City</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 14</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Springfield State Hospital</b>		d. STREET ADDRESS <b>5010 Crossword Ave.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Estellae Mae Hopkins Spicer</b>		4. DATE OF DEATH Month Day Year <b>August 12, 1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></b>	8. DATE OF BIRTH <b>1884</b> <b>January 15, 1884</b>
9. AGE (In years last birthday) <b>76 7/4</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min. <b>76 7/4</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Hopkins</b>		14. MOTHER'S MAIDEN NAME <b>Mary -</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>Springfield Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>422.1</b> (c) <b>422.1</b> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>C.B.S. assoc. with senile brain disease with psychotic reaction.</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>Years</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>James T. Marsh</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>James T. Marsh, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8-15-60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Leonard J. Ruck</b>		24a. REC'D BY REGISTRAR <b>15 60</b> DATE	
ADDRESS <b>5305 Harford Rd</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Ruck</b>	

BP 1

2012 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

<p>1. DECEASED'S NAME (Last, First, Middle Initial)                  _____</p>		<p>2. SEX                  Male <input type="checkbox"/> Female <input type="checkbox"/></p>	
<p>3. DATE OF BIRTH                  _____</p>		<p>4. PLACE OF BIRTH                  _____</p>	
<p>5. DECEASED'S RESIDENCE                  _____</p>		<p>6. DECEASED'S OCCUPATION                  _____</p>	
<p>7. DECEASED'S MARITAL STATUS                  Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/></p>		<p>8. DECEASED'S RACE                  _____</p>	
<p>9. DECEASED'S ETHNICITY                  _____</p>		<p>10. DECEASED'S RELIGION                  _____</p>	
<p>11. DECEASED'S SOCIAL SECURITY NUMBER                  _____</p>		<p>12. DECEASED'S MEDICAL HISTORY (List conditions)                  _____</p>	
<p>13. DECEASED'S PRE-EXISTING CONDITIONS                  _____</p>		<p>14. DECEASED'S MEDICATIONS (List drugs)                  _____</p>	
<p>15. DECEASED'S ALLERGIES (List allergies)                  _____</p>		<p>16. DECEASED'S SURGICAL HISTORY (List surgeries)                  _____</p>	
<p>17. DECEASED'S SMOKING HISTORY                  Never <input type="checkbox"/> Former <input type="checkbox"/> Current <input type="checkbox"/></p>		<p>18. DECEASED'S ALCOHOL CONSUMPTION                  Never <input type="checkbox"/> Occasional <input type="checkbox"/> Regular <input type="checkbox"/></p>	
<p>19. DECEASED'S CAUSE OF DEATH (List cause)                  _____</p>		<p>20. DECEASED'S MANNER OF DEATH                  Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined <input type="checkbox"/></p>	
<p>21. DECEASED'S UNDERLYING CAUSE OF DEATH                  _____</p>		<p>22. DECEASED'S IMMEDIATE CAUSE OF DEATH                  _____</p>	
<p>23. DECEASED'S CONTRIBUTING CAUSE OF DEATH                  _____</p>		<p>24. DECEASED'S DEATH CERTIFICATE NUMBER                  _____</p>	
<p>25. DECEASED'S SIGNATURE                  _____</p>		<p>26. DECEASED'S DATE OF SIGNATURE                  _____</p>	
<p>27. DECEASED'S ADDRESS                  _____</p>		<p>28. DECEASED'S CITY                  _____</p>	
<p>29. DECEASED'S STATE                  _____</p>		<p>30. DECEASED'S ZIP CODE                  _____</p>	



## BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9016

## CERTIFICATE OF DEATH

08989

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural, New London, MD 21550</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural, New London, MD #1</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Western Chapel Road</u>				d. STREET ADDRESS <u>Western Chapel Road</u>			
3. NAME OF DECEASED (Type or print) <u>MARY ELIZABETH THOMAS</u>				4. DATE OF DEATH Month <u>AUGUST</u> Day <u>30</u> Year <u>1960</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 1, 1877</u>	9. AGE (In years last birthday) <u>83</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Carroll Co. Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Israel Adams</u>			
14. MOTHER'S MAIDEN NAME <u>Rebecca ?</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>  </u> (If yes, give war or dates of service) <u>  </u>			
16. SOCIAL SECURITY NO. <u>216-32-6935</u>				17. INFORMANT <u>Mrs. Ruth M. Fletcher</u> Address <u>Same address</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) <u>HYPERTENSIVE ARTERIOSCLEROTIC</u> DUE TO (c) <u>CARDIOVASCULAR DISEASE</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 DAY</u> <u>5 YRS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>JULY, 1959</u> , to <u>AUG. 30, 1960</u> , that I last saw the deceased alive on <u>AUG 30, 1960</u> , and that death occurred at <u>11:30 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>19 RIDGE RD</u> DATE SIGNED <u>AUG 30, 1960</u>							
ACTUAL SIGNATURE <u>William I. Stewart, M.D.</u>				PHYSICIAN'S NAME (Type) <u>WESTMINSTER, MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept. 3, 60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Western Chapel Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>New London, MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Taylor, Jr., Westminster, Md.</u>				24a. REC'D BY REGISTRAR <u>SEP 1 '60</u>		24b. REGISTRAR'S SIGNATURE <u>William S. Taylor</u>	



# 1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

<div>Item 18 Film 275 11-23-60 am</div> <div> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>8984 MEDICAL EXAMINER'S CERTIFICATE OF DEATH</b> </div> <div>118990</div>											
<b>1. PLACE OF DEATH</b> a. COUNTY <b>Carroll</b> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Westminster</b> c. LENGTH OF STAY IN 1b <b>1 yr. 1 day</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>19 Ridge Road</b>						<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>27 Westminster</b> d. STREET ADDRESS <b>1 54 Chase Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) <b>WILLIAM R. VEIGA</b> <b>4. DATE OF DEATH</b> <b>August 15 1960</b>						<b>5. SEX</b> <b>Male</b> <b>6. COLOR OR RACE</b> <b>White</b> <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>B. DATE OF BIRTH</b> <b>Dec 3, 1957</b> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/> <b>9. AGE</b> (In years last birthday) <b>2 yrs.</b> <b>IF UNDER 1 YEAR</b> <b>IF UNDER 24 HRS.</b> Months Days Hours Min.					
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>None</b> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>—</b> <b>11. BIRTHPLACE</b> (State or foreign country) <b>Baltimore Md.</b> <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>						<b>13. FATHER'S NAME</b> <b>Joseph V. Veiga, Jr.</b> <b>14. MOTHER'S MAIDEN NAME</b> <b>Jane Gillespie</b> <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (yes, no, or unknown) <b>—</b> <b>16. SOCIAL SECURITY NO.</b> <b>—</b> <b>17. INFORMANT</b> <b>Mr. J. V. Veiga, Jr. Westminster Md.</b> <b>Address</b> <b>54 Chase St.</b>					
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute, interstitial pneumonitis, bilateral</b> <b>492x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>—</b> DUE TO (c) <b>—</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>—</b> <b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b> <b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>20c. TIME OF INJURY</b> Month, Day, Year <b>19</b> <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> <b>(County)</b> <b>(State)</b>											
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input checked="" type="checkbox"/> <b>Inspection</b> <input type="checkbox"/> <b>Inquiry</b> <input type="checkbox"/> <b>and in my opinion death resulted from:</b> Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> <b>ACTUAL SIGNATURE</b> <b>Russell S Fisher</b> <b>M.D.</b> <b>CHIEF MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <b>EXAMINER'S NAME (Type)</b> <b>Russell S. Fisher, M.D.</b> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DATE SIGNED</b> <b>8/15/60</b> <b>Address (Street, city, town, or county)</b>											
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>22b. DATE THEREOF</b> <b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>22d. LOCATION (City, town, or country)</b> <b>(State)</b> <b>REMOVAL AUG. 18, 1960</b> <b>Calvary Cemetery</b> <b>Chicopee, Mass.</b> <b>23. FUNERAL DIRECTOR</b> <b>24a. REC'D BY REGISTRAR</b> <b>24b. REGISTRAR'S SIGNATURE</b> <b>J. E. Myers Jr., Westminster, Md.</b> <b>DATE</b> <b>AUG 18 '60</b> <b>Arthur S. Kraus</b>											

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may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

9017

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

08991

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto. City</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. LENGTH OF STAY IN 1b <b>4yrs.3mos.22days</b> <b>Baltimore 24</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				d. STREET ADDRESS <b>505 S. East Ave.</b> <b>3V01-4</b>			
3. NAME OF DECEASED (Type or print) First <b>June</b> Middle <b>Esther</b> Last <b>(Wisniewski)Wallace</b>				4. DATE OF DEATH Month <b>August</b> Day <b>23</b> Year <b>19 60</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>June 25, 1899</b>	
9. AGE (In years lost birthday) <b>61</b> yrs.		10. AGE (In years lost birthday) <b>61</b> yrs.		11. BIRTHPLACE (State or foreign country) <b>Michigan</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None House wife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>217-20-2346</b>		11. BIRTHPLACE (State or foreign country) <b>Michigan</b>	
13. FATHER'S NAME <b>Albert Wisniewski</b>				14. MOTHER'S MAIDEN NAME <b>Ida - Staniewski</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT <b>Wm. D. Wallace 1923</b> Address <b>Quentine Rd 22</b> <b>Springfield Hospital Records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> DUE TO <b>422.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost. (b) <b>Pyelonephritis</b> DUE TO (c) <b>Bronchopneumonia</b>							INTERVAL BETWEEN ONSET AND DEATH <b>Years</b> <b>Weeks</b> <b>Days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Schizophrenic reaction, paranoid type.</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>May 31, 1955</b> to <b>August 23, 1960</b> , that (I) (we) last saw the deceased alive on <b>August 23, 1960</b> , and that death occurred at <b>8:10PM</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Agustin del Campo</b>				22b. DATE <b>8/24/60</b>			
22c. PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b>				22d. ADDRESS <b>Springfield Hospital, Sykesville, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8/27/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Stanislaus</b>		23d. LOCATION (City, town, or county) (State) <b>Balto. City Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. S. Fialkowski 2007 Eastern Ave.</b>				25a. REC'D BY REGISTRAR DATE <b>AUG 25 60</b>		25b. REGISTRAR'S SIGNATURE <b>William S. Fialkowski</b>	

103

CERTIFICATE OF DEATH

103

Form with multiple lines for text entry, including fields for name, date, and location. The text is faint and mostly illegible.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

118992

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>28 days</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> 2103-2
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		d. STREET ADDRESS <b>806 Mulberry Ave.</b>	
3. NAME OF DECEASED (Type or print) First <b>Rudolph</b> Middle <b>Max</b> Last <b>Weiss</b>		4. DATE OF DEATH Month <b>August</b> Day <b>25</b> Year <b>19 60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>December 10, 1883</b>
9. AGE (In years last birthday) <b>76</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Silk mill employee</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>WEAVER</b>	
11. BIRTHPLACE (State or foreign country) <b>Germany</b>		12. CITIZEN OR WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>ADOLPH WEISS</b>		14. MOTHER'S MAIDEN NAME <b>Agnes Elsberg</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>15-05-969</b>	
17. INFORMANT <b>Springfield Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b> DUE TO <b>Generalized arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>C.B.S. associated with senile brain disease.</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>Years</b> <b>Years</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>July 27, 1960</b> to <b>August 25, 1960</b> , that (I) (we) lost the deceased on <b>August 25, 1960</b> , and that death occurred at <b>10:15 AM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Agustin del Campo</b>		22b. DATE <b>8/25/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b>		22d. ADDRESS <b>Springfield Hospital, Sykesville, Md.</b>	
23a. BURIAL, CREMATION, OR REMOVAL (Specify) <b>Buried</b>		23b. DATE THEREOF <b>8/27/60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Cedarhawn Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>Hagerstown Md</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>W.J. Normant</b>		25a. REC'D BY REGISTRAR <b>DATE AUG 29 1960</b>	
ADDRESS <b>Hagerstown, Md</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kimes</b>	

1

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has

page 3 should be detached for use as the burial

the State Board of Health prior to burial

the attending physician and

tely filled in by the funeral director,

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

9019

## CERTIFICATE OF DEATH

08993

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Carroll</b> <span style="float: right;"><b>MARYLAND</b></span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Henryton</b> c. LENGTH OF STAY IN 1b <b>180 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Henryton State Hospital</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Colton's Point</b> d. STREET ADDRESS <div style="text-align: center; font-size: 2em; margin-top: 10px;">18X-2</div> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>													
<b>3. NAME OF DECEASED</b> (Type or print) <b>Alias Walter Jefferson</b> Middle <b>Walter Thomas Young</b> Last				<b>4. DATE OF DEATH</b> Month <b>August</b> Day <b>20</b> Year <b>1960</b>													
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1-1-1874</b>		9. AGE (In years last birthday) <b>86</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Oyster Shucker</b>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <b>St. Mary's Co., Md.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>					
13. FATHER'S NAME <b>Thomas Young</b>						14. MOTHER'S MAIDEN NAME <b>Henrietta Young</b>											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO.				17. INFORMANT <b>Walter Thomas Young - Patient</b> Address									
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiovascular insufficiency</b> <div style="margin-top: 10px;"> <b>002X</b> Part II          Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic heart disease</b>          DUE TO (c) <b>Moderately advanced pulmonary Tbc.</b> </div>												INTERVAL BETWEEN ONSET AND DEATH					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)														19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <b>Feb. 22, 1960</b> to <b>Aug. 20, 1960</b> , that (I) (we) last saw the deceased alive on <b>Aug. 20, 1960</b> , and that death occurred at <b>310P</b> , from the causes and on the date stated above.																	
22a. SIGNATURE <b>Edgars M. Maculans</b> M.D.								ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED					
22c. PHYSICIAN'S NAME (Type) <b>Dr. Edgars M. Maculans, Supt.</b>								22d. ADDRESS <b>Henryton State Hospital, Henryton, Md</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>8/23/60</b>				23c. NAME OF CEMETERY OR CREMATORY <b>All Saints</b>				23d. LOCATION (City, town, or county) (State) <b>Oakley, Md.</b>					
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. CLARKE MATTINGLEY</b>								ADDRESS <b>LEONARDTOWN, MARYLAND</b>				25a. REC'D BY REGISTRAR <b>AUG 23 '60</b>				25b. REGISTRAR'S SIGNATURE <b>Arthur L. Young</b>	

02003

CERTIFICATE OF DEATH

00100

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TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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VS A15 (4)  
15M 9/58  
BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9020

## CERTIFICATE OF DEATH

Reg. Dist. No.

08394

1. PLACE OF DEATH a. COUNTY <b>Carroll County</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Carroll</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural- Westminster, Md.</b>		c. LENGTH OF STAY IN 1b <b>5 yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural- Westminster, Md.</b>		d. STREET ADDRESS <b>Old Washington Road R.D. # 6 Westminster, Md.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION -----		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		4. DATE OF DEATH <b>Aug. 13 19 60</b>		Day Year	
3. NAME OF DECEASED (Type or print) <b>Thomas Gloyd Zendgraft</b>		First Middle Last		5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 30, 1906</b>		9. AGE (In years last birthday) <b>53</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>boiler-fireman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>laundry</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Albert G. Zendgraft</b>		14. MOTHER'S MAIDEN NAME <b>Mary E. Buckingham</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>218-03-6900</b>	
17. INFORMANT <b>sister- Mrs. Joseph H. Martin</b>		Address <b>R.D. #6 Westminster, Md.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatosis</b> <b>153.8</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Original site - colon</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b> 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I attended the deceased from <b>8/30/58</b> to <b>8/13/60</b> 19 <b>60</b> , that I last saw the deceased alive on <b>8/13/60</b> , 19 <b>60</b> , and that death occurred at <b>10 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>New Windsor, Md.</b> DATE SIGNED <b>8/13/60</b> ACTUAL SIGNATURE <b>M.E. Robertson</b> M.D. PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/16/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Westminster Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Westminster Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James G. Saffell</b>		ADDRESS <b>Westminster Md.</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 15 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>	

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 9021 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68995  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto.</b> City <b>City</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. LENGTH OF STAY IN 1b <b>20yrs. 4mos. 14days</b> <b>Baltimore</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Springfield State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Pearl</b> Middle <b>Ziegler</b> Last <b>Ziegler</b>				4. DATE OF DEATH Month <b>August</b> Day <b>4</b> Year <b>19 60</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 23, 1899</b>	
9. AGE (In years last birthday) <b>61</b> yrs.		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>		IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerical work</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Unk</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Andrew Ziegler</b>				14. MOTHER'S MAIDEN NAME <b>Margaret Yakel</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT Address <b>Springfield Hospital Records.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> DUE TO <b>420-1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>A.S.C.V. disease</b> DUE TO (c) <b>years</b>							INTERVAL BETWEEN ONSET AND DEATH <b>Days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Schizophrenic reaction, paranoid type. Free nt lip</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Patient fell to the floor on the ward.</b>					
20c. TIME OF INJURY Month, Day, Year <b>7:00 PM 7/17/ 1960</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Hospital</b>		20f. (City or town) (County) (State) <b>Sykesville Carroll Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>James T. Marsh</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>James T. Marsh, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8-8-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur A. Haight Sykesville, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>AUG 10 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur A. Haight</b>	

DATE SIGNED

8/4/60

